State of California
Business, Transportation and Housing Agency
Department of Managed Health Care
INDEPENDENT MEDICAL REVIEW APPLICATION-English
DMHC 20-086 New: 01/02 Rev: 04/06

HMO Help Center

State of California
Department of Managed Health Care

Independent Medical Review Application

If you want to give another person the authority to assist you with your IMR, you must also complete the Authorized Assistant Form.

Patient Information

First Name _____ Middle Initial _____ Last Name _____

Name of Parent or Guardian if Filing for Minor Child _____

Street Address _____

City _____ State _____ Zip _____

Day Phone # _____ Evening Phone # _____

Health Plan Name _____

Patient's Health Plan Membership Number _____

Patient's Date of Birth (mm/dd/yy) _____

Do you have Medi-Cal? ☐ Yes ☐ No

Do you have Medicare or Medicare Advantage? ☐ Yes ☐ No

Have you filed a complaint or grievance with your health plan? ☐ Yes ☐ No

Are you seeking payment for a service that you have already received? ☐ Yes ☐ No

Your Health Problem

(Use a separate sheet and attach other documents if needed.)

1. What is your health condition or doctor's diagnosis? _____
2. What medical treatment or service are you requesting? _____
3. How would you like this case to be decided? _____
4. Do you have a condition that is a serious threat to your health? ☐ Yes ☐ No

   If "yes," please explain. _____
5. Did your health plan say that the treatment you want is (check one):

   ☐ Not medically necessary ☐ Experimental or investigational ☐ Other _____
6. List the name and phone number of your primary care doctor and other doctors who have seen, treated or advised you for your condition. Are they in your health plan's network? (Use a separate sheet if needed.)

   _____
7. I am asking for an Independent Medical Review (IMR) to make a decision about my problem with my health plan. I allow my providers, past and present, and my health plan to release my medical records and information for this IMR. These records may include medical, mental health, substance abuse, HIV, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case. I allow the Department of Managed Health Care (DMHC) and IMR staff to review these records and information. My permission will end one year from the date below, except as allowed by law. For example, the law allows the DMHC to continue to use my information internally. I can end my permission sooner if I wish. All the information that I have provided on this sheet is true.

Patient or Parent Signature _____ **Date** _____

Mail or fax this form and any attachments to: **HMO Help Center, Department of Managed Health Care, IMR Unit, 980 9th St., Suite 500, Sacramento, CA 95814; FAX: 1-916-255-5241**

State of California
Business, Transportation and Housing Agency
Department of Managed Health Care
AUTHORIZED ASSISTANT FORM-English
DMHC 20-160 New: 04/06

HMO Help Center

State of California
Department of Managed Health Care

Authorized Assistant Form

- If you want to give someone the authority to assist you in your Independent Medical Review (IMR) or complaint, fill in Parts A and B below.
- If you are a parent or legal guardian filing this IMR or complaint for a child under the age of 18, you do not need to complete this form.
- If you are filing this IMR or complaint for a patient who cannot complete this form and you have legal authority to act for this patient, please complete Part B only. Also send a copy of the power of attorney for health care decisions or other legal document that says you can make decisions for the patient.

Part A: Patient

I allow the person named below in Part B to assist me in my IMR or complaint filed with the Department of Managed Health Care (DMHC). I allow the DMHC and IMR staff to share information about my medical condition(s) and care with the person named below. This information may include mental health treatment, HIV treatment or testing, alcohol or drug treatment, or other health care information.

I understand that only information related to my IMR or complaint will be shared.

My approval of this assistance is voluntary and I have the right to end it. If I want to end it, I must do so in writing.

Patient Signature _____ Date_____

Part B: Person Assisting Patient

Name of Person Assisting (print)_____

Signature of Person Assisting _____

Address _____

Relationship to Patient _____

Daytime Phone # _____

Evening Phone # _____

☐ My power of attorney for health care decisions or other legal document is attached.

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This Notice Is Required by Law*

California's Knox-Keene Act gives the Department of Managed Health Care (DMHC) the authority to regulate health plans and investigate the complaints of health plan members.

- The DMHC's HMO Help Center uses your personal information to investigate your problem with your health plan and to provide an Independent Medical Review if you qualify for one.
- You give us this information voluntarily. You do not have to give us this information.
- However, if you do not give us the information, we may not be able to investigate your complaint or provide an Independent Medical Review.
- We may share your personal information, as needed, with the health plan and the doctors who are doing the Independent Medical Review.
- We may also share your information with other government agencies as required or allowed by law.
- You have a right to see your personal information. To do this, contact the DMHC Records Request Coordinator, DMHC, Office of Legal Services, 980 Ninth Street, Suite 500, Sacramento, CA 95814-2725, (1-916-322-6727).

* The law that requires this notice is the Information Practices Act of 1977 (California Civil Code Section 1798.17).